UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Xibrom (bromfenac sodium)

Patient name:_____Medicaid or SS# _____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt._____ Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

DOCUMENTED prior trial of any indicated medication*.

AUTHORIZATION:

Approved for one bottle for a 2 week period following procedure or surgery.

RE-AUTHORIZATION:

Same as initial authorization.

*Other indicated medications include diclofenac, ketorolac, nepafenac, loteprednol, rimexolone, or prednisolone opthalmic preparations.

4/8/8